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Ethical and Spiritual Guidelines Regarding the Withholding and/or Withdrawing of Medical Treatment

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A. Introduction

The ethical issue of withholding and withdrawing medical treatment is currently receiving renewed interest in the literature of medical ethics, not to mention current court decisions. The intent of this paper is to reflect on ethical and spiritual guidelines flowing from Catholic moral and pastoral teaching which relate to this contemporary, complex issue.

B. Ethical Guidelines

Catholic health care facilities and their employees are dedicated to preserve and enhance the value, dignity and quality of life of patients. Based on this philosophy, we must address the complex ethical and moral issues of death and dying confronting health professionals in our institutions.

The Christian belief is that life is, indeed, a basic good, but at the same time, a good to be preserved and regarded in due relation to other values. These other values are related to a belief in a life hereafter, and determine and dictate the limits to the obligation to preserve life and to delay dying.

These principles do not reflect any fundamental devaluation of human life; rather, they formulate some common sense perceptions. Biological life is a limited relative value which we are not obliged to preserve or protect at all costs. Therefore:

1. The obligation to preserve one's life and care for one's health is, of its very nature, a limited one. In other words, there is a limit to what we are obligated to do in order to preserve life and impede or delay death. Christians believe that through death, life is merely changed, not taken away and that death need not be resisted with every possible means. Dying is a natural part of life which should be made as comfortable as possible

for the patient and should not be unnecessarily prolonged. Not unduly prolonging the dying process affirms belief in eternal life.

2. In accord with its philosophy and tradition, Catholic health care has the responsibility to respect and preserve the patient's choices of care in all the stages of illness, including the state of dying. The preservation of the patient's choice will be consistent with current Catholic medical-moral teachings.

3. Competent patients, or those closest to them, have the knowledge or understanding of the particular situation. Therefore, competent individuals should decide for themselves, unless there is a substantial reason for not doing so. If this is the case, then a person so designated by the patient or next of kin should participate in the decision-making process. The role of the health care team is generally not to make this decision for the patient and family, but rather to provide information and support to assist their decision-making.

4. It has been stressed that a basic right of a patient is to make decisions regarding his/her treatment. Crucial to the decision-making process is informed consent. Informed consent means that a competent patient understands the nature and extent of his/her illness, various alternatives including non-treatment, and the advantages and disadvantages of various modalities of care. This information should be presented by the health care team in layman's terms. It is helpful to ask the patient questions in order to see if he/she clearly understands.

5. An incompetent patient, however, cannot make these judgments under these circumstances. It is imperative that the patient's physician and health care team consult the family representatives. The family has the duty to discern or interpret the patient's own wishes about whether to forego treatment or remove life-sustaining equipment. In such circumstances, even though the patient's wishes are unknown, an incompetent patient's physician, with the family's approval, may consider foregoing CPR, respiratory assistance, and other treatments which prolong the dying process. The judgment that such procedures are ethically optional in these cases rests on the uselessness of prolonging dying.

6. Intravenous feeding and internal tubes can be considered ethically non-obligatory in the final stage of terminal illness and in irreversible coma. When artificial nourishment merely prolongs the final stage of dying, Catholic ethical teaching permits withdrawing it because of the treatment's uselessness. Nourishment must never be withdrawn contrary to a patient's own wishes, of course, and comfort measures must be provided. Many ethicists would hold that the withdrawing of artificial nourishment can also be ethically justified in cases of irreversible coma because the coma has become an indefinite extension of the dying process's final phase.

7. Withdrawing life-sustaining procedures is morally permissible when life-sustaining procedures are prolonging the final stage of the terminal illness. In making these decisions, the following ethical guidelines should

be considered:

A. Withdrawing life-sustaining procedures must never be contemplated as a means of hastening death; it can be considered in the context of avoiding over treatment or unnecessarily prolonging suffering.

B. The patient's attending physician should retain ultimate responsibility for all treatment decisions in accord with the patient's or family's consent. Consultation with other physicians and the appropriate decision of the health care facility's medical ethics committee is advisable.

C. Life-sustaining procedures may never be withdrawn without a competent patient's consent.

D. Every effort must be made to determine an incompetent patient's own wishes in regard to life-sustaining procedures.

E. In every case involving withdrawing life-sustaining procedures for an incompetent patient, careful consideration must be given both to the ethical evaluation of the decision and to the legal requirements of the state in which your health facility is located.

These points offer guidelines for the complex ethical and legal issues. They flow from the Catholic tradition of stewardship of human life.

C. Spiritual Guidelines:

Mercy is a healing quality and it is essential that Catholic facilities have something extra to offer besides physical treatment, namely emotional, spiritual, psychological and social support.

1. To facilitate truth spoken in love to patients diagnosed as critical or terminal is certainly a primary guideline. Family, friends, and patient — all need the continued unfailing support of doctors, nurses, ancillary staff and caring pastoral persons. Out of this support may grow sharing that will make the illness a time of bridge-building, of expressions of love, of healing relationships, of treasured hours of communication, even when no words are being spoken.

2. Pastoral care staff should be alerted to all patients who are critically or terminally ill so that meaningful spiritual communication can occur. Life being lived under the pressure of threatened life span can take on a sacramental dimension. Actions, words, sense of humor, beliefs, and values of the person are lifted up into a spiritual awareness.

3. The sacraments and prayers should be administered appropriately according to that patient's denominational pastoral practices and procedures.

4. Hospital staff personnel, whatever their work assignment, can jointly, team up to provide support, to show the patient and family that they are respected human beings, and that threatened life has an important meaning and a unique place in human history.

5. These ministries extend to all — especially the critically and terminally ill and their families regardless of creed, race, sex and age. Illness and death are a time for people to come together to provide support and love.

II. Summary

1. Biologic life need not be preserved at all costs. There are times when it is more in keeping with respect for life to let it go than to cling to it.

2. A decision to withhold or withdraw treatment which is potentially life-prolonging does not mean the staff has abandoned a patient, but rather represents the time for an intensification of efforts to provide for the physical, psychosocial, and spiritual needs of the individual.

3. Although a competent adult generally has the right to participate in directing the course of his or her own medical treatment, this right is not an absolute one. Careful consideration of the status as an adult, minor, infant, in relation to competency and incompetency is necessary during the decision-making process.

It is hoped these guidelines speak to the reality of the complex ethical and human aspects of death and dying. Without some such guidelines, health care personnel in Catholic facilities would merely be involved in arbitrary decisions or worse, decisions which are both unethical and inhuman, as they do not include an awareness of and confrontation with the Catholic ethical tradition.
